SPACE MAINTENANCE

Guideline Number: DCG035.04
Effective Date: January 1, 2020

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<td>Space Maintainers are contraindicated for the following:</td>
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<td>Related Policies</td>
<td>None</td>
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DEFINITIONS

Necessary: Dental Services and supplies which are determined through case-by-case assessments of care based on accepted dental practices to be appropriate; and
- Needed to meet your basic dental needs; and
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the dental service; and
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted; and
- Consistent with the diagnosis of the condition; and
- Required for reasons other than the convenience of you or your dental provider; and
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  o Safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; or
  o Safe with promising efficacy:
    ▪ For treating a life threatening dental disease or condition; and
    ▪ In a clinically controlled research setting; and

Instructions for Use

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Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health

**Space Maintainer**: A passive appliance, usually cemented in place, that holds teeth in position. (ADA)

### APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Clinical Policies and Coverage Guidelines may apply.

<table>
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<tr>
<th>CDT Code</th>
<th>Description</th>
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<tr>
<td>D1510</td>
<td>Space maintainer – fixed – unilateral – per quadrant</td>
</tr>
<tr>
<td>D1516</td>
<td>Space maintainer – fixed – bilateral, maxillary</td>
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<td>D1517</td>
<td>Space maintainer – fixed – bilateral, mandibular</td>
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<td>D1520</td>
<td>Space maintainer – removable – unilateral – per quadrant</td>
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<tr>
<td>D1526</td>
<td>Space maintainer – removable – bilateral, maxillary</td>
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<tr>
<td>D1527</td>
<td>Space maintainer – removable – bilateral, mandibular</td>
</tr>
<tr>
<td>D1551</td>
<td>re-cement or re-bond bilateral space maintainer – maxillary</td>
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<tr>
<td>D1552</td>
<td>re-cement or re-bond bilateral space maintainer – mandibular</td>
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<tr>
<td>D1553</td>
<td>re-cement or re-bond unilateral space maintainer – per quadrant</td>
</tr>
<tr>
<td>D1556</td>
<td>removal of fixed unilateral space maintainer – per quadrant</td>
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<tr>
<td>D1557</td>
<td>removal of fixed bilateral space maintainer – maxillary</td>
</tr>
<tr>
<td>D1558</td>
<td>removal of fixed bilateral space maintainer – mandibular</td>
</tr>
<tr>
<td>D1575</td>
<td>Distal shoe space maintainer – fixed – unilateral – per quadrant</td>
</tr>
<tr>
<td>D1999</td>
<td>Unspecified preventive procedure, by report</td>
</tr>
</tbody>
</table>

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### DESCRIPTION OF SERVICES

Space Maintainers are passive appliances designed to prevent tooth movement following premature loss of primary teeth so permanent teeth can erupt into proper position. Additionally, the goal of space maintenance is to prevent loss of arch length, width and perimeter by maintaining the relative position of the existing dentition.

### REFERENCES


American Dental Association (ADA) CDT 2020 Dental Procedure Code Book.

American Dental Association (ADA). Glossary of Dental Clinical and Administrative Terms.


### GUIDELINE HISTORY/REVISION INFORMATION

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| 01/01/2020 | **Coverage Rationale**  
**Exclusions**  
- Added list of coverage **Exclusions** to reflect/include:  
  - Dental services that are not Necessary |

Space Maintenance  
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INSTRUCTIONS FOR USE

This Dental Coverage Guideline provides assistance in interpreting UnitedHealthcare standard dental benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard dental plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Dental Coverage Guideline is provided for informational purposes. It does not constitute medical advice.

Date | Action/Description
--- | ---
| o Any dental procedure not directly associated with dental disease
| o Procedures that are considered to be experimental, investigational or unproven; any treatment, device or pharmacological regimen that is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be an experimental, investigational or unproven service

Applicable Codes
- Updated list of applicable CDT codes to reflect annual code edits:
  - Added D1551, D1552, D1553, D1556, D1557, and D1558
  - Removed D1550 and D1555
  - Revised description for D1510, D1520, and D1575

Definitions
- Added definition of “Necessary”

Supporting Information
- Archived previous policy version DCG035.03